Reset

The STANDARD INSURANCE

State of Arizona
Life Insurance Benefits
Proof of Death Employer Statement

Standard Insurance Company, Life Benefits Department
PO Box 2800 Portland OR 97208-2800 866.440.4846 Tel

Forms may be returned for unanswered questions.

Name of Deceased:	Effective Date of Member's Insurance:
Social Security Number:	Date of Membership/Employment:
Date of Birth:	Date member last reported for work :
Date of Death:	Reason member did not return to work: ☐ Death ☐ Illness ☐ Other *(explain)* _____
If Dependent Claim, Name of Member:	Last month premium was paid for member or dependent:
Group Policy Number: **617950**	Monthly or annual salary: $
Insurance Class *(see contract)* :	Date of last salary increase:
Amount of insurance claimed: Basic life $ _____ Dependent life $ _____ Additional life $ _____ Nonsmoker Benefit $ _____ Accidental death $ _____ Other *(specify)* $ _____	Salary prior to increase: $ Usual number of hours employee worked per week: Amount of monthly premium paid for the insured:
Member also had the following claims with Standard Insurance Company: *(check all that apply)* ☐ Long Term Disability ☐ Waiver of Premium ☐ Short Term Disability	Member was: *(check all that apply)* ☐ Full-Time ☐ Union ☐ Hourly ☐ Part-Time ☐ Non-Union ☐ Salaried ☐ Commissioned ☐ Active ☐ Retired

Name of Beneficiary	Relation	Date of Birth	Address	Phone

Remarks:

In addition to this form, the following items are required.

- Beneficiary Statement.
- Original enrollment forms and any subsequent beneficiary changes.
- Certified death certificate.
- For AD&D and Seat Belt Claims, newspaper clippings, police and accident reports, or other information regarding the accident.

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

I acknowledge that I have read and received the fraud notice listed below.

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Signature of Authorized Benefit Administrator Date	**State of Arizona** Name of Employer or Association
(Please print) Benefit Administrator's Name	Street Address
(_____) _____ Phone Number	City State Zip Code

Payments of $10,000 or more are paid via SSA and will be sent directly to beneficiary, unless requested otherwise.

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